A 28pgs 268 (2)

No. 06-1053

IN THE

United States Supreme Court

CLINTON SEWELL, M.D.
CARICARE MEDICAL SERVICES, P.C.,

Petitioners,

v.

THE 1199 NATIONAL BENEFIT FUND FOR
HEALTH AND HUMAN SERVICES,

Respondent

On Writ of Certiorari to the
United States Supreme Court

PETITION FOR REHEARING

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REASON FOR GRANTING A REHEARING OF WRIT

This case concerns the rights of physicians to sue as ERISA assignees in defense of their right to bill an ERISA plan and is of national importance inasmuch as there now exists a whirlwind type of overpayment recoupment crisis by plans like Appellee which withholds subsequent claim payments amounting to millions of dollars because federal and state agencies have turned a deaf ear to a healthcare provider's cry for justice due to a jurisdiction issue, while state government decline to intervene because of ERISA preemption and while federal government refuse to investigate because of alleged provider network contract agreement dispute. In the interim, healthcare providers receive no payments or little payments for already approved claims as a result of "overpayment" recoupment by the payers. This is an injustice which warrants the highest Court's review of this case.

The decisions of both the District Court and the Second Circuit affects over 800,000 physicians who provide medical services to members of ERISA-based health plans. Despite the presence of a blatant conflict of interest, the decisions of both the District Court and the Second Circuit have granted to Appellee and other health plans the authority to bypass ERISA's Claims Procedure by using mathematical analyses to form the sole basis to determine the validity of the medical claims for services provided by the health care providers.

ERRORS OF THE COURT OF APPEALS

The Court of Appeals makes certain assertions and misstatements in its decision which warrants a review of this

case by this Honorable Court. The Second Circuit ruling was based upon conclusions that reflect a misreading of the facts of this case.

1. Sewell was an Assignee with full ERISA rights. In its decision, the Second Circuit stated the following:

> At the time relevant to this appeal, Sewell was a participating provider under the Plan. His relationship with the Fund was governed by a Physician Participation Agreement with the Fund and included a fee schedule for covered services. According to the SPD, participating providers like Sewell "accept the Fund's payment as payment in full" for covered services, and the Plan's participants or beneficiaries receive care for those services "at no cost." When a participant or beneficiary uses a non-participating provider, by contrast, he or she "can be billed whatever the doctor normally charges" and the participant will "have to pay any cost over the Fund's allowance" for the service provided.

Pet. for Cert. A 6a n.1. Appellants do not dispute that Dr. Sewell agreed to "accept the Fund's payment as payment in full" for covered services. In fact, Dr. Sewell did accept the Fund's payment as payment in full. There is nothing in the record that Dr. Sewell filed appeals challenging the amount which he received from Appellee and there is nothing in the record that Dr. Sewell billed the members for any cost over the Fund's allowance. Finally, Dr. Sewell did not bring this action to challenge the payment which he received from the Appellee, which was far less that the charge for his services as set forth on the claim forms submitted to Appellee, but rather this case was brought to recover monies which had been placed in a withholding status, while there was no review pursuant to ERISA's Claims Procedure.

The Second Circuit's ruling is contradicted by Appellee's own Summary Plan Description which provides:

> A claim form needs to be filled out and sent to the Fund so that your doctor or health care provider can be paid . . .

(A-2a)

> If you want the Fund to reimburse your provider, you must sign the Assignment of Benefits statement on your claim form. . . .
>
> Note: The assignment feature of the Fund is only for payment of your benefits to providers . . . .

(A-4a)

From a reading of the Second Circuit's decision, it is clear that the Court has created a loophole for Appellee by suggesting that assignments were not permitted for Appellants, as participating providers.[1] The problem here is Appellee made no distinction in its Summary Plan Description between assignments to participating versus nonparticipating providers. Dr. Sewell fully followed the directives set forth in Appellee's Summary Plan Description. The fact that Appellee did not expect Appellants to obtain assignment from patients does not void the validity of the assignment forms. Further, the claim form[2] used by providers, both par-

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[1] This position is contradicted in the Medicare Claims Processing Manual, Chapter 26, in that the Form HCFA 1500 now known as Form CMS-1500, the basic form prescribed for claims from physicians and adopted by the American Medical Association (AMA Council on Medical Services, states that the patient's signature authorizes "payment of benefits to provider of services when the provider of service accepts assignment of the claim." *Medicare Claims Processing Manual, Chapter 26, Completing and Processing Form CMS-1500 Data Set.*

[2] *See Medicare Claims Processing Manual, Chapter 26, Completing and Processing Form CMS-1500 Data Set.*

ticipating and nonparticipating, is a mandatory form filed with the health plan by the provider in order to receive payment. There is no distinguishing feature for participating versus nonparticipating providers. There is also no language in Appellee's SPD which waives the filing of this claim form because the physician is a participating providers under Appellee's health care plan.

2. The Court of Appeals statement, "The Fund requires its medical providers to submit bills for payment using the American Medical Association's (AMA) procedure codes (the 'codes')" (Pet. for Cert. A-4a). The first part of the statement which follows, reads, "Each code corresponds to a particular treatment . . ." (Pet. for Cert. A-4a) is consistent with the intent of the AMA for the use of these codes as outlined in its published guidelines for CPT code selection—1995 Documentation Guidelines for Evaluation and Management Services. The second part of the statement, which reads ". . . and a dollar amount that the Fund has agreed to pay" (Pet. for Cert. A-4a) is a monetary assignment that the Fund has applied to these codes by criteria that were never agreed upon by the parties nor the AMA, and are yet unknown to Sewell.

In the usual course of his business, Sewell established a system of monetary assignment to CPT codes which utilizes the AMA selection criteria generated from the patient encounter in conjunction with the Medicare fee schedule to derive an amount to be charged for patient encounters. The code selection was verified upon medical record review by the testimony of the Fund's Medical Director. Comparison of the amounts charged by Appellant with the Fund's fee schedule shows that the Fund did not accept Appellant's fee as set forth on the claim form but paid a lower fee that did not exceed Appellee's fee schedule. Yet, the Fund continues to view the code selection used for the

patient encounter as "improper billing practices" and upcoding,[3] and have summarily downcoded the code selection and recouped monies without the inconvenience of verification by document reviews or claim denial notification and appeals as required by the ERISA statutes, but nevertheless justifiable on the basis of discretionary fiduciary authority. Implications from the use of these codes as the AMA intended and their use as billing codes as the Fund requires, presents a conflict, which the Fund circumvents by avoiding documentary review of the denied claims on the basis of fiduciary authority. CPT codes and billing codes are not equivalent and are not interchangeable, and the actions of the Fund's committee therefore warrants review and should not be accorded the customary deference allowed ERISA plan administrators. The Fund's recoupment activities on the basis of self-determined statistical deviations without documentary review establishes a previously unstated condition that the use of certain more expensive codes beyond an unspecified frequency implies upcoding, and will result in recoupment action in the form of downcoding of future claims without regard to whether AMA code selection criteria were satisfied by the selection of this code.

3. The Court of Appeals' assertion that because the benefit plan gives the administrator discretionary authority, "The parties agree" that the "Fund's denial of benefits" should be reviewed under an "arbitrary and capricious standard," is untrue. *See* Pet. for Cert. A-7a. There was never such an agreement. By way of coincidence both parties chose the same standard of review but for diametrically opposite reasons. Sewell's supplication to the court was to seek a meas-

[3] It is the result of this incorrect view that the Court of Appeals felt that Sewell used "more expensive codes than those that accurately reflect the services provided". Pet. for Cert. A-4a.

ure of relief from the action by the Fund of summary recoupment of monies on the basis of its own unchallenged statistical reviews and suspicions of ongoing improper billing practices only, and that as an ERISA sponsored plan the Fund had an obligation to initiate the review and appeals process that is mandated by ERISA when claims for benefits are denied, which would then permit Sewell to present in his own defense, a complete record for review by the Fund. Sewell contended that these actions were statutorily unsupported and prejudicial, and therefore arbitrary and capricious. It was the Fund in its defense that stated that its actions were supported by its discretionary authority to construe the terms of the Plan subject to its own interpretations and objectives. The Court of Appeals made no mention of Sewell's argument that his rights as an ERISA assignee were denied.

4. The Court of Appeals raised the issue that Participating Providers provide service "at no cost" to the beneficiary, as outlined in the Plan's Summary Plan Description, because the beneficiary does not file a claim and is not required to give assignment for the provider to be paid. This raises the question as to the source of monies that pay participating providers. Are they members' benefits? If so, they are subject to ERISA regulations and claims procedures. Additionally, Sewell obtained valid assignments making his claims payable from members' benefits and subject to the ERISA claims procedures.

CONFLICTS AMONG THE CIRCUITS WITH SUPREME COURT *FIRESTONE* RULING

Because the Circuits are divided on the applicable standard of review where the fiduciary clearly operates under a conflict of interest, rehearing is appropriate to clarify the confusion that exists among the Circuits. Further, this peti-

tion presents an ideal opportunity for resolution of the correct standard of review when a fiduciary like the one at bar acts pursuant to a conflict of interest and its final decision is monetary based. The issue here is as significant as the damages issue raised in the *State Farm Mut. Auto Ins. Co. v Campbell*, 538 U.S. 408 (2003).

The degree of deference accorded by the Federal judiciary to ERISA Plan fiduciaries[4] in the circumvention of ERISA statutes in the disposition of assigned medical claims is being brought to the United States Supreme Court for the first time, and is of major importance to over 800,000 physicians in the United States.[5]

The question which Appellee asks this Court to consider is whether Appellants have established a "split in the circuits" which would warrant the granting of this writ of certiorari. The answer is clearly yes. The petition of certiorari reveals facts that detail repeated non-compliance by several circuits with this Court's order in *Firestone*. The review process employed by the Second Circuit stands in stark contrast to the procedure outlined and mandated by this Court in *Firestone*. The procedural history of petitioner's case, as well as the records of similar actions brought throughout the country reveal glaring "conflicts" which authorize the granting of the

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[4] ERISA § 404(a)(1)(A) imposes a duty upon fiduciaries by requiring that "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries." 29 U.S.C. 1104(a)(1)(A)

[5] Almost all health insurance in the United States—except for Medicare—is provided through employer-sponsored plans and is subject to ERISA. *See* Loraine Schmall & Brenda Stephens, ERISA Preemption: *A Move Towards Defederalizing Claims for Patients' Rights*. 142 Brandeis L.J. 529, 538 (2004).

certiorari. *Title 28 U.S.C. 2106* confers broad powers on the Supreme Court to vacate any judgment lawfully before it for review and to remand the cause for such action as may be fair under the circumstances. *Lawrence v. Chater*, 516 U.S. 163, 166 (1996). Granting certiorari, vacating, and remanding this case is appropriate and fair because of the likelihood that doing so will prevent the onslaught of recoupment that has been heaped upon the medical community. Finally, the decision below perpetuates a manifest injustice that the district court and the Court of Appeals have proven themselves unwilling to address. Under the precedent set by the Second Circuit, many,—if not most—of the physicians will find themselves locked out of the halls of justice because they have no recourse in a Federal or State court.

ERISA DOES NOT PROVIDE A RECOUPMENT REMEDY

This case is appropriate for rehearing because the issue it presents—the recoupment of monies already paid—is of extraordinary importance, both under ERISA's remedies provision, and in its impact on the ability of assignees of ERISA participants and beneficiaries who have been harmed by fiduciary withholding and recoupment without any recourse in a court of law.

The Second Circuit has decided an important question of federal law affecting ERISA assignees that has not been, but should be, settled by this Court. The recoupment permitted in this case has created a precedent whereby Appellee can, and has, undertaken an action of downcoding all claims submitted by Appellants to it without regard to whether the patient encounter satisfied the AMA code selection criteria. The absence of any reference to, or support under, ERISA in either the District Court or the Sec-

ond Circuit's decision has opened the door for summary downcoding and recoupment without Appellee being inconvenienced by document reviews or claim denial notifications and appeals as required by the ERISA statutes. In fact, other than this case, there are no cases in the Second Circuit in which equitable restitution has been awarded to a plan fiduciary for a disputed overpayment to a health care provider. *See Vacca v Trinitas Hospital*, 2006 WL 3314637 (E.D.N.Y. Nov. 14, 2006)

NATIONAL IMPLICATIONS

The ruling of the Second Circuit permits fiduciaries to ignore their statutory obligations, injure assignee physicians, and evade liability. Assignee physicians are thus left without a remedy against fiduciaries who have committed serious violations of ERISA's provisions, in particular ERISA's claims procedure.

A cursory review of the cases suggests the range of injuries that could go unredressed if the Second Circuit's decision remains standing given the number of health plans in the United States. Under the present ruling, ERISA plans may completely ignore the ERISA claims procedures for denial of claims from medical providers, and participating providers in particular. Plans, on the other hand, have developed a profitable business entity in its relationship with contracted physicians, and executed by committees created in the name of fraud and abuse on the basis of self-prescribed fiduciary authority, which is beyond the scope of current federal current law, and is now legalized by the Second Circuit's ruling. It is respectfully submitted that Congress did not anticipate this unprecedented scam which has not been fully disclosed to physicians or members participating under the health plan.

This case shows that as a result of unclear guidelines from the United States Supreme Court, the Second Circuit and several other circuits, have applied an arbitrary and capricious standard of review to the illegal actions of fiduciaries, and have permitted Funds like Appellee to create a system of review that is not only contrary to ERISA but is also unprecedented. This unfettered discretion permits Appellee to ignore federally mandated guidelines which are set forth in ERISA's Claims Procedures while engaging in and its overpayment recoupment scheme. This case represents the unspoken power that has been vested by the Second Circuit into Appellee and other health plans whereby an internal mathematical review system is substituted for documentary review in order to determine the validity of a physician's CPT code selection.

CONCLUSION

WHEREFORE, Appellants respectfully request that the Petition for Rehearing be granted.

Respectfully submitted,

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Maspeth, New York 11378
718-426-0444

ATTORNEY CERTIFICATION

Deveraux Cannick certifies as follows:

1. This Petition for Rehearing is restricted to the grounds specified in Rule 44.2.

2. The Petition for Rehearing is presented in good faith and not for delay.

Deveraux Cannick, Esq.
Attorney for Appellants

PLAINTIFF'S EXHIBIT 2

[HANDWRITTEN OVER AN IMAGE AT BOTTOM]
Getting Your Benefits

IN THIS SECTION

GETTING YOUR HEALTH CARE BENEFITS

- YOUR ID CARDS
- FILING A CLAIM FORM
- FEE NEGOTIATION PROGRAM
- QUALITY CARE ASSESSMENT

FILING FOR DISABILITY BENEFITS

FILING CLAIMS FOR OTHER BENEFITS

WHEN BENEFITS MAY BE WITHHELD OR DENIED

WHAT IS NOT COVERED

ADDITIONAL PROVISIONS

YOU CAN APPEAL

RESOURCE GUIDE

Who to Call

Member Services Department
212-307-7500

- If you have any questions regarding your ID cards
- If you need any claim forms
- If you have questions about completing your claim form

- For more information about the Fee Negotiation Program when you use non-participating providers
- If you have any questions about what is not covered by the Fund
- If you have any questions about the processing of your claim
- If you need information on appealing your claim

[IMAGE OF A CLERK BY A COMPUTER SCREEN]

GETTING YOUR HEALTH CARE BENEFITS

YOUR ID CARDS

When you become eligible for benefits, the Fund will send you a **Health Service ID card**.

If you are participating in the Member's Choice program, the Fund will also send you a Member's Choice **card**.

You may need these cards whenever you:

- Go to the doctor
- Go to the hospital
- Get a prescription filled.

FILING A CLAIM FORM

A claim form needs to be filled out and sent to the Fund so that:

- Your doctor or health care provider can be paid

or

- You can be reimbursed if you paid your doctor or health care provider.

If you use a participating provider, your doctor, hospital or health care provider will send the claim form to the Fund.

If you use a non-participating provider, you need to send your claim form to the Fund.

PROMPT, COMPLETE CLAIMS CAN BE PROCESSED FASTER

Get a Claim Form Before You Go to See Your Provider

Claim forms are available at the Fund office or by calling the Members Services Department at 212-307-7500.

If you use participating providers, they will have claim forms at their office.

- **Print Your Information**

Your claim can be processed faster if your form is filled out completely. Clearly print all the information requested:

- The member's name, address, and social security number

and

- The patient's name and birth date.

- **Have Your Provider Complete His or Her Section**

Your doctor, hospital or health care provider has to provide the Fund with information about your care, including:

- The date of the visit
- A list of services provided
- Diagnosis.

He or she needs to sign and date the form.

- **Sign the Assignment of Benefits Section**

If you want the Fund to reimburse your provider, you must sign the Assignment of Benefits statement on your claim form. This way, you are giving the Fund your consent to have the payment sent to your doctor, hospital or health care provider.

Note: The assignment feature of the Fund is only for payment of your benefits to providers. There is no further liability for any claim by any provider or third party and no such claims may be brought against the Fund.

- **Send Your Claim To The Fund**

It is very important to send your claim form to the Fund promptly:

Disability claims must be filed **within 30 days** of the start of your disability

All other claims must be filed **no longer than 90 days** after the services were provided

Life insurance and AD&D claims must be filed **no longer than one year** after the date of death or loss.

The Plan Administrator, at its sole discretion, may allow a claim to be filed late due to extenuating circumstances. But, the Fund will not pay claims filed *more than one year* after the service or treatment is provided.

QUALITY CARE ASSESSMENT

Your Fund is concerned about the quality of the care you and your family receive.

If our medical or dental advisor has questions about your claim, the Fund may send it to an independent spe-

cialist to review. In some cases, the Fund may require that you be examined by a specialist chosen by the Fund.

There is no cost to you for this consultation.

PHYSICIAN FEE NEGOTIATING PROGRAM

It's hard to discuss fees with your doctors or other health care providers. But when you use a non-participating provider, you may have a high out-of-pocket cost. Your Fund may be able to help.

To Get Help from the Fund

When you use a non-participating provider:

- Fill out your claim form
- Ask your provider to accept Assignment of Benefits.

Through the Fee Negotiation Program, the Fund will negotiate with your doctor and try to reduce or eliminate your out-of-pocket cost.

In many cases, doctors have accepted the Fund's reimbursement as full payment for your care. In other cases, the Fund was able to reduce members' out-of-pocket cost, even though they still had to pay part of the bill.

There is no guarantee that the Fund will be able to cut your out-of-pocket expenses. Therefore, we urge you to use a participating provider.

WHEN BENEFITS MAY BE WITHHELD OR DENIED

It is important that you provide the Fund with all the information, documents or other material it needs to process your claim for benefits.

The Fund may be unable to process your claim if you, your spouse or your children:

- Do not repay the Fund for benefits that you were not entitled to receive
- Do not sign an agreement (or comply with such an agreement) to repay the Fund in the case of legal claim against a third party
- Do not sign the Assignment of Benefits authorization when you want your benefits paid directly to your provider
- Do not allow the disclosure of medical information, medical records or other documents and information when requested by the Fund.

FUND'S RIGHT TO CONFIRM CLAIMS

Before paying any benefits, the Fund may require that:

You, your spouse or your children be examined by a doctor or dentist selected by the Fund as often as required during the period of the claim

An autopsy be performed to determine the cause of death, except where prohibited by law.

[IMAGE OF A WOMAN HOLDING A BABY]

WHAT'S *NOT* COVERED

In addition to the various exclusions set forth elsewhere in this booklet, the Fund does not cover:

- Charges in excess of the Fund's Schedule of Allowances

- Charges for services provided and supplies or appliances used before you, your spouse or your children became eligible for Fund coverage
- Charges for services covered under any mandatory automobile or no-fault policy
- Charges related to any work-related accidental injuries or diseases which are covered under Workers' Compensation or comparable law
- Charges for care resulting from an act of war
- Charges related to an illness or injury that was deliberately self-inflicted or that resulted from the person participating in an illegal act
- Charges for services or materials which do not meet the Fund's standards of professionally recognized quality
- Charges that would not have been made if no coverage existed or charges that neither you nor any of your dependents are required to pay. For example, the Fund will not pay for services provided by members of your or your dependent's immediate family.
- Charges made by your provider for broken appointments
- Charges for in-hospital services that can be performed on an ambulatory or outpatient basis
- Charges for treatment performed only for cosmetic purposes, except to remedy a condition that results from an accidental injury which occurred while covered by the Fund
- Charges for experimental or unproven procedures, services, treatments, supplies, devices, drugs, etc. (*see definition on page 107*).
- Charges for services, treatments and supplies covered under any other insurance coverage or plan, or

under a plan or law of any government agency or program

- Charges for services that are not FDA approved for a particular condition
- Charges that are unreasonable, excessive, or that are beyond the provider's normal billing rate.
- Charges for services that are not covered by the Fund
- Charges for services that are not medically necessary in the judgement of the Plan Administrator
- Charges related to interest, late charges, finance charges, court or other legal costs
- Charges related to programs for smoke cessation, weight reduction, stress management and other similar programs which are not provided by a licensed medical physician or not medically necessary
- Charges for claims submitted more than 12 months after the date of treatment
- Charges related to an illness or injury resulting from the conduct of another person, where payment for those charges is the legal responsibility of another person, firm, corporation, insurance company, payor, uninsured motorist fund, no-fault insurance carrier or other entity.

ADDITIONAL PROVISIONS

- Nothing in this booklet shall be construed as creating any right in any third party to receive payment from this Fund.
- Payments shall not be made to a person who is:
  - A minor (under age 18)
  - Unable to care for his or her affairs due to illness, injury, or incapacity.

Instead, the payment shall be made to a duly appointed legal representative or to such person who, in the judgement of the Plan Administrator, is maintaining or has custody of the person entitled to payments.

- No legal action may be brought against the Fund or the Trustees until all remedies under the Fund have been exhausted, including requests for Administrative reviews or appeals.
- Payments made by the Fund which are not consistent with the Plan—as stated in this booklet or as it may be amended—must be returned to the Fund.
- No benefit payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge.

Any action by way of anticipating, alienating, selling, pledging, encumbering or charging the same shall be void and of no effect. Nor, shall any benefit be in any manner subject to the debts, contracts, liabilities, engagements, or torts of the person entitled to such benefit.

Notwithstanding the foregoing, the Fund shall have the power and authority to authorize the distribution of benefits in accordance with the terms of a court order that it determines is a qualified medical child support order, as required by applicable Federal law.

YOUR RIGHTS ARE PROTECTED— YOU CAN APPEAL

If your entire claim, or part of your claim is denied, you have the right to appeal.

Any and all claims by you, your spouse/domestic partner, your children, your beneficiaries or third parties against the Fund, must first be reported to and reviewed

by the Plan Administrator before they shall become the subject of litigation in either State or Federal Court.

APPEALING DISABILITY CLAIMS

You will receive a notice of rejection if:

- Your claim for disability benefits is denied

or

- You are not paid for the full period of disability you claimed.

The reason for the rejection will be stated.

To appeal this ruling, you must:

- Follow the directions that are on the back of the rejection notice (DB-451). If you do not have this form available, contact the Fund at 212-307-7500.

and

- *Within 30 da*ys, send the request for a review in writing to the applicable State agency.

Your claim will be reviewed and you will receive a written notice of the decision from the State.

If your appeal is denied, you may request an Administrative Review from the Fund, by sending a letter to the Fund *within 60 days.*

APPEALING ALL OTHER BENEFIT CLAIMS

When you claim is fully denied, partially denied or your benefits have been reduced, you will receive a written notice from the Plan Administrator *within 90 days* from the date your claim is received by the Fund office.

The reason why your benefits have been denied or reduced will be given and you will be told of the specific provisions of the Plan on which the decision is based.

In special circumstances, more than 90 days may be needed to process your claim and make a decision. In this case, you will be sent a notice of an extension *within 90 days* from the date your claim is received, stating why additional time is needed. If your claim is denied, you will be sent a notice *within 180 days* from the date your claim is received.

If you do not receive a notice of denial or notice of an extension within 90 days from the date your claim is received, you should consider your claim denied and request an appeal.

To appeal:

- **You must write to the Plan Administrator within 60 days** of the date you receive the notice of denial, asking for a review of the decision
- You, or your authorized representative, have the right to request a review of documents pertinent to your claim and to send written comments or questions to the Plan Administrator
- If your claim is denied following this administrative review, you will receive a written notice informing you of the decision
- You can then make a final appeal directly to the Appeals Committee of the Board of Trustees.

MAKING A FINAL APPEAL

Send a letter to the Plan Administrator **within 60 days** of the administrative review decision

Your appeal will be considered by the Appeals Committee of the Board of Trustees. If you elect to do so, you will be permitted to appear personally before the Appeals Committee, along with a representative of your choice

You should receive a written decision from the Appeals Committee usually **within 60 days** after the Committee receives your request for a review. The notice will give the specific reason(s) for the decision and the specific provisions of the Plan on which the decision is based

If extra time is needed to make a decision, you will be sent a written notice of extension. The review will take **no longer than 120 days** after the Committee receives your request for a review.

Written notice of the extension shall be furnished to you before the extension begins. If you do not receive a decision or a notice of an extension within the appropriate period, you should consider your appeal to be denied on review.

All decisions of the Appeals Committee shall be in writing and shall be final and binding on all parties affected by it.

AUTHORITY OF THE PLAN ADMINISTRATOR

Notwithstanding any other provision in the Plan, and to the full extent permitted by ERISA and the Internal Revenue Code, the Plan Administrator shall have the exclusive right, power and authority, in its sole and absolute discretion:

- To administer, apply, construe and interpret the Plan and any related Plan documents

- To decide all matters arising in connection with entitlement to benefits, the nature, type, form, amount, and duration of benefits and the operation and administration of the Plan
- To make all factual determinations required to administer, apply, construe and interpret the Plan (and all related Plan documents).

Without limiting the generality of the statements above, the Plan Administrator shall have the ultimate discretionary authority to:

(i) Determine whether any individual is eligible for any benefits under this Plan;

(ii) Determine the amount of benefits, if any, an individual is entitled to under this Plan;

(iii) Interpret all of the provisions of this Plan (and all related Plan documents);

(iv) Interpret all of the terms used in this Plan;

(v) Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;

(vi) Decide questions, including legal or factual questions, relating to the eligibility for, or calculation and payment of, benefits under the Plan;

(vii) Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other related Plan documents; and

(viii) Process and approve or deny benefit claims and rule on any benefit exclusions.

All determinations made by the Plan Administrator (or any duly authorized designee thereof) and/or the Appeals Committee with respect to any matter arising

under the Plan and any other Plan documents shall be final and binding on all parties.

[National Benefit Fund logo]

For Health and Human Service Employee:

National Benefit and Pension Funds: (646) 473-9200
Greater New York Benefit Fund:• (212) 541-9150
• Pension Fund: • (646) 473-8666
Home Care Employees Benefit and Pension Funds:
• (646) 473-9200
Home Health Aide Benefit Fund: (646) 473-7470

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330 West 42nd Street, New York, N.Y. 10036-6977
• www.1199nbf.org

Via Overnight Mail

March 11, 2004

Clinton Sewell, MD
Caricare Medical Services
230-11 Linden Boulevard
Cambria Heights, N.Y. 11411

Dear Dr. Clinton:

The 1199 National Benefit Fund has been in contact with you regarding your billing practices, which have resulted in overpayments from the Fund. You have responded with information that does not provide an acceptable response to our reviews. The basis for our reviews is the Current Procedural Terminology (CPT 2004) from the American Medical Association, which are the acceptable criteria for most payers. I have enclosed the section on Evaluation and Manage-

ment. We have also included a detailed listing of Provider Claims Detail that has bearing on our review.

Since you were unwilling to resolve this as we first suggested, in a continued review of your billing patterns and practices, your payments have been withheld pending resolution of this matter.

In further effort to resolve this matter, we are requesting that you send us a legible photocopy of the medical record for each of our Members listed on the attached sheet. In order to expedite the review process, be sure to include all relevant information (including but not limited to: history and physical exams, progress notes, laboratory results, radiological reports/findings, for all visits during the period of May 1, 1999 through March 31, 2003. Please send these records within fifteen (15) days of receipt of this request.

The Fund considers upcoding to be a very serious violation and it intends to pursue these situations vigorously. If I do

not receive your records within fifteen (15) days, we will have to pursue all available remedies to resolve this.

Sincerely,

/s/ Ruth Antoniades
Ruth Antoniades UDC
Special Program Coordinator

Encl.

cc: Frank Hagen, Director
Kate Botley, Assistant Director
Celia Shmukler, M.D.

All of these Funds are jointly administered, benefits are subject to each Fund's Summary Plan Description (SPD) and the discretion of the Trustees of that Fund.